SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	**DOH. 17-11**
RE: ANN MARIE MECHTENBERG, RN	:	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF SUSPENSION**
License No. R028205,	:	
Licensee.	:	

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The South Dakota Board of Nursing's ("Board") hearing on the summary suspension of Ann Marie Mechtenberg, RN, license number R028205 ("Licensee") came before the Board at its office in Sioux Falls, South Dakota, on February 9, 2018, at 10:30 a.m.

Licensee was originally served with an Order for Summary Suspension and Notice of Hearing along with the supporting Affidavit of Kathleen Tinklenberg by sending a copy of the pleadings to Licensee's then attorney, Melissa C. Hinton, on September 4, 2013. Said Notice provided that the hearing on the summary suspension would be held on a date to be determined. The hearing was delayed pending additional investigation of the nursing facility where Licensee was employed, as well as additional investigation specific to complaints made against Licensee, as well as Licensee's subsequent change of counsel.

On August 23, 2017, at 9:49 p.m., Licensee was served with an Amended Notice of Hearing via process server at her address at 3408 East Bahnson Circle, Sioux Falls, South Dakota 57103. Said hearing was to take place before the Board on October 24, 2017, beginning at 9:00 a.m.

Following that service, the Board received an e-mail communication dated October 23, 2017, from an Elizabeth Evans ("Evans") who advised she was acting as Licensee's "legal and medical representative." Evans indicated that Licensee was not able to participate in the hearing that was scheduled before the Board due to a pedestrian/vehicle accident. Evans advised that Licensee would return to Sioux Falls on October 27, 2017, and would advise the Board how Licensee wished to proceed. When no communication was received from Evans or Licensee, an Amended Notice of Hearing was prepared with a Certificate of Service dated December 12, 2017, with service made via certified and regular mail to Licensee's address as well as by e-mail to Evans. Said hearing was set to take place on February 9, 2018, at 10:30 a.m.

Licensee, having been served with the Order for Summary Suspension and Notice of Hearing and the supporting documentations, did not appear in person to present evidence on her behalf or to confront witnesses. The Board appeared by and through its attorney, Kristine K. O'Connell. Administrative Law Judge Catherine Duenwald presided over the proceeding. The proceeding was transcribed by a court reporter.

The Board considered testimony given by the Board Investigator, Francie Miller, as to the previous disciplinary matters regarding the Licensee. The Board was also provided with the affidavit and other public documents on file in this case and being charged with the statutory obligation to protect the public health, safety and welfare set forth in SDCL § 36-9, including the protection of the public from unsafe nursing practices and practitioners, the Board hereby makes the following:

FINDINGS OF FACT

1. That the Licensee is licensed to practice as a registered nurse in the State of South Dakota and holds license number R044614.

2. On June 22, 2006, the Licensee was issued a Letter of Reprimand with Remediation.

3. This Letter of Reprimand arose out of a complaint from two prospective employers to which the Licensee provided falsified letters of reference.

4. Licensee admitted to submitting these fraudulent letters of reference in an attempt to secure employment.

5. On November 13, 2007, the Board issued a Notice of Hearing on an Order for Summary Suspension for the Licensee following complaints received on April 7, 2007, from the Licensee's then long term care employer in regard to medication errors, and possible diversion of narcotics.

6. The same employer indicated that the Licensee had also been disciplined for sleeping on the job, not responding to patient lights, leaving medication room doors open, not documenting appropriately, and other practice intervention issues.

7. Prior to hearing on that summary suspension, the Board, on June 24, 2007, received another complaint from a subsequent long term care employer alleging unsafe practice issues including medication errors, incorrect counting of narcotics (no diversion), and laboratory errors during Licensee's employment from May to July 2007.

8. A due process hearing was held on June 19, 2008. Following the hearing, the Board entered its Findings of Fact, Conclusions of Law and entered its Order of Reinstatement with Probation.

9. The Board found that the Licensee had taken the appropriate steps to address the issues that were raised at the June 19, 2008, hearing.

10. The Order of Reinstatement with Probation was issued on September 16, 2008.

11. The Licensee was placed on probationary status for a period of one year with quarterly reports to be submitted to the Board for a period of one year of nursing practice.

12. Due to the Licensee's sporadic and inconsistent practice as a nurse following that hearing, her probationary period was never closed.

13. On April 1, 2012, Licensee began employment with another long term care facility.

14. On or about August 16, 2012, the Board received a call from the Administrator of Licensure and Certification Programs at the South Dakota Department of Health. The Department of Health informed the Board of the closure of a long term care facility in which Licensee was working as a nurse.

15. The Department of Health Surveys raised concerns regarding nursing practices that had been identified at the long term care facility, including the practices of the Licensee.

16. These issues were documented in the Department of Health Survey dated July 30, 2012.

17. In particular, the Surveys identified inconsistencies surrounding a resident's fall in comparison to the documentation and the Licensee's testimony given to the Surveyors.

18. Another concern raised by the Department of Health Survey involved a number of medication errors made by the Licensee as it related to controlled substances, destruction, co-signing, and other medication administration errors committed by the Licensee.

19. Following the complaint, investigation by the Board began, as did an investigation of the facility by the DCI.

20. On or about January 2, 2013, the Board received a complaint against the Licensee from a daughter of a resident of the long term care facility alleging that the Licensee failed to clearly communicate pertinent information to the daughter after her father's fall at the facility and his impending transfer to a hospital.

21. Licensee failed to tell the daughter of the severity of the resident's condition (orbital fracture) and the significance of his changing vital signs.

22. Shortly thereafter, another complaint was brought to the Board by a former CNA of the long term care facility.

23. This complainant reported an incident involving the Licensee's lack of nursing care to a resident who was in respiratory distress and discomfort, while tending to another resident's wound vac equipment for most of her shift.

24. Licensee's assessments and documentation were inadequate in regard to these patients.

25. The Licensee was interviewed by DCI and the Department of Health regarding issues identified for patients she had cared for.

26. As a result of these investigations, there was a delay in setting the Licensee's Informal Meeting (which was initially set for January 29, 2013) until it was determined if charges would be brought by the authorities or not.

27. When the determination was made that the Licensee was not going to face any charges, the Informal Meeting was held on June 18, 2013, which offered the Licensee an opportunity to discuss the complaints alleged.

28. At the Informal Meeting, the Licensee provided information about her business called "Puzzled Pathways."

29. This business provided coaching for children with ADHD. She stated that she had 25 children that she was working with at that time.

30. The Licensee also shared that she was working with adolescents at the Keystone Treatment Center three days a week for 12-hour shifts.

31. She indicated that Keystone was willing to provide quarterly probation reports on her behalf as they were made aware the Licensee was still on probation.

32. Sometime following the Informal Meeting, the Licensee was terminated from Keystone.

33. The Licensee's termination from Keystone (7/19/2013) occurred prior to the issuance of the Order for Summary Suspension.

34. The only nursing job that Licensee had following the closure of the long term care facility was at Keystone.

35. The coaching that she provided to the ADHD children did not require a nursing license.

36. The Board was aware of Licensee's continuing nursing practice following the closure of the long term care facility as she remained on probation.

37. The information regarding the Board's investigation of the complaints against the Licensee was presented to the full Board on July 19, 2013.

38. At that meeting, the Board voted to request a Voluntary Surrender Consent Order of the RN license of Licensee and if that was not agreed upon, a Summary Suspension and Notice of Hearing was to be issued.

39. The Board issued the summary suspension as the Board found that the public health, safety or welfare imperatively required emergency action based upon the concerns that were raised because of the complaints.

From the foregoing findings of fact, the Board draws the following:

CONCLUSIONS OF LAW

1. That the Board has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-1.1 and 36-9-49.

2. That the Licensee's conduct as identified in the findings of fact is in violation of SDCL §§ 36-9-49 (5), (7) and (10).

THEREFORE, let an order be entered accordingly.

ORDER

Based on the Findings of Fact and Conclusions of Law, the South Dakota Board of Nursing hereby orders:

1. That the Licensee's license to practice nursing in the State of South Dakota is hereby indefinitely suspended.

2. That the Licensee is hereby notified that any practice of or holding herself out as a registered nurse during the term of this suspension is in violation of SDCL § 36-9-68.

4. That Licensee may petition for reinstatement of her license at any time for "good cause" pursuant to SDCL § 36-9-57.

Dated this 13th day of March, 2018.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, RN, MS
Executive Director

The South Dakota Board of Nursing, at the hearing on the 9th day of February, 2018, approved this Order of Suspension as written by a vote of 8-0, and issues its Order of Suspension consistent herein.

IT IS HEREBY ORDERED that the above Order of Suspension is adopted as an Order of the South Dakota Board of Nursing on this 13th day of March, 2018.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, RN, MS
Executive Director